

Army Regulation 40–35

Medical Services

**Dental
Readiness and
Community
Oral Health
Protection**

**Headquarters
Department of the Army
Washington, DC
2 August 2004**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-35

Dental Readiness and Community Oral Health Protection

Specifically, this revision--

- o Adds the responsibilities of the Chief of the U.S. Army Dental Corps (para 4b) and the U.S. Army Dental Command (para 4d).
- o Requires that personnel in dental organizations adopt protocols provided by the Prevent Abuse and Neglect through Dental Awareness Program for identification and referral of suspected cases of abuse and neglect (para 4f(6)).
- o Establishes the goal of having 95 percent of all active duty forces in dental class 1 and class 2 (para 4h(6)).
- o Provides criteria for dental classifications (para 6b).
- o Updates the dental screening procedures for permanent duty soldiers who are inprocessing (paras 6c(1)(a) and 6c(1)(b)).
- o Deletes the requirement for a duplicate panoramic radiograph (para 6c(1)(c)).
- o Adds the provision, that, whenever available, depending on local dental assets and availability of time during the training cycle, soldiers in basic training or advanced individual training are required to have a dental readiness examination (para 6c(2)).
- o Stipulates that soldiers in dental class 3 or class 4 will not be cleared for overseas movement or deployed unless a waiver is granted (paras 6c(5) and 6c(6)).
- o Prescribes the use of DD Form 2813 (DOD Active Duty/Reserve Forces Dental Examination) (para 6d).
- o Contains updated guidance on fluoride therapy in health promotion (para 7c).
- o Revises the reporting requirements of RCS MED 399, the Community Oral Health Protection Report (formerly called the Preventive Dentistry Report) (para 9).

Effective 2 September 2004

Medical Services

Dental Readiness and Community Oral Health Protection

By order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This publication is a major revision.

Summary. This regulation defines the Army Dental Readiness and Community Oral Health Protection programs; fixes responsibility for administration and implementation of the programs and details procedures for their execution; defines the dental readiness classification scheme and sets forth procedures for assigning dental readiness classes; and fixes responsibilities and establishes procedures for completing and forwarding the Community Oral Health Protection Report.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United

States (ARNG/ARNGUS) and the U.S. Army Reserve. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General of the United States Army. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated (see app B).

Supplementation. Supplementation of

this regulation and establishment of command and local forms are prohibited without prior approval of HQ U.S. Army Dental Command (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234–6000.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQ U.S. Army Dental Command (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234–6000.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army and the Army National Guard/Army National Guard of the United States, and D and E for the U.S. Army Reserve (medical activities only); and for command levels B, C, D, and E for the Active Army and the Army National Guard/Army National Guard of the United States, and D and E for the U.S. Army Reserve (all other activities).

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*This regulation supersedes AR 40–35, dated 26 March 1989; HQDA Letter 40–01–2, dated 2 July 2001; and HQDA Letter 40–03–1, dated 2 July 2003.

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Glossary

1. Purpose

Dental readiness is fundamental to maintaining unit readiness and reducing non-combat dental casualties during deployments. Community oral health protection emphasizes not only oral health, but also general wellness and overall fitness of our soldiers and all authorized beneficiaries. This regulation provides guidance for the development and conduct of the Dental Readiness and the Community Oral Health Protection programs for all authorized beneficiaries of the U.S. Army Dental Care System. It describes the Dental Readiness Program for active duty soldiers and other programs that benefit all members of the Army community.

2. References

Required and referenced publications and prescribed and referenced forms are listed in appendix A.

3. Explanation of abbreviations and terms

Abbreviations and terms used in this publication are explained in the glossary.

4. Responsibilities

a. The Surgeon General (TSG), based on guidance from the Assistant Secretary of Defense for Health Affairs, will approve policy concerning the Army Dental Readiness and Community Oral Health Protection Programs.

b. The Chief of the U.S. Army Dental Corps will—

- (1) Make recommendations to TSG concerning dental readiness and community oral health protection.
- (2) Appoint a Public Health Dentistry Consultant.
- (3) Advise TSG on the dental readiness of all Army components.
- (4) Advise the Assistant Secretary of Defense for Health Affairs on the dental readiness of the Army.

c. The Public Health Dentistry Consultant appointed by TSG will—

(1) Advise on all matters pertaining to public health dentistry, community preventive dentistry, and health promotion.

(2) Semiannually review the Community Oral Health Protection Report (RCS MED 399) (formerly known as the Preventive Dentistry Report) and report significant findings to the Office of the Chief of the Dental Corps.

d. The Commander, U.S. Army Dental Command (DENCOM) and the Commander of the 618th Dental Company (AS) will—

(1) Assume responsibility for the administration of policies in this regulation.

(2) Appoint a dental officer to monitor dental readiness and health promotions for the command.

e. DENCOM's Dental Public Health Officer or the designated staff officer for Dental Readiness and Health Promotion will—

(1) Advise the Commander, DENCOM on the command's Dental Readiness Program.

(2) Monitor and evaluate the command's operation of the Community Oral Health Protection Program.

(3) Semiannually, consolidate the Community Oral Health Protection Report from all subordinate units and submit it to the DENCOM Commander.

(4) Provide a copy of the semiannual Command Community Oral Health Protection Report to TSG's consultant in Public Health Dentistry within 30 days of its submission to the DENCOM Commander.

f. Commanders of dental activities (DENTACs), dental clinic commands (DCCs), and separate dental units (Active Army) will—

(1) Ensure compliance with this regulation.

(2) Appoint on orders a dental officer as the DENTAC, DCC, dental unit dental readiness officer (DRO).

(3) Appoint, if appropriate, additional officers to represent designated units, activities, or patient catchment areas on the installation.

(4) Advise unit commanders, on a monthly basis, on the dental readiness of their command. They will also train unit commanders how to access dental readiness information through the Medical Protection System (MEDPROS) and the Corporate Dental Application (CDA).

(5) Identify requirements for training in oral disease, injury prevention, and health promotion.

(6) Support the Family Advocacy Program on Family Violence in accordance with AR 608-18. They will adopt protocols provided by the Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) Program for identification and referral of suspected cases of abuse and neglect.

g. Commanders, U.S. Army Medical Activities and Commanders, U.S. Army Medical Centers will—

(1) Provide the necessary administrative and logistical support required to ensure successful Dental Readiness and Community Oral Health Protection Programs.

(2) Provide water quality reports that include fluoride concentration to the DENTAC, DCC, or dental unit commander (or designated representative) on at least a quarterly basis (see TB MED 576).

(3) Provide water quality reports to geographically dispersed dental facilities under their general command and control.

h. Commanders of units supported by the Dental Readiness Program will—

(1) Monitor dental appointments within their units and act to reduce failed appointments.

(2) Make personnel available to receive dental care (both for annual examinations and routine treatment), thus improving both the dental readiness (dental class 1 and class 2 combined) and oral wellness (dental class 1) of unit personnel.

(3) Assure that personnel in dental class 3 or class 4 are available for expedited dental care.

(4) Coordinate with the DENTAC/DCC/dental unit commander for available treatment times.

(5) Coordinate with the DENTAC/DCC/dental unit commander to audit and monitor dental health records and record accountability.

(6) Assure that the unit dental readiness posture meets the goal established by the Secretary of Defense for Health Affairs, which is to have 95 percent of all active duty forces in dental class 1 and class 2 (see HA Policy 96-024).

i. Dental readiness officers will—

(1) Assist DENTAC/DCC commanders/dental unit commanders/directors of dental services in implementing the Army Dental Readiness Program.

(2) Plan, organize, implement, and evaluate the activities of the Community Oral Health Protection Program. Where appropriate, the DRO may seek the assistance of the community health dental hygienist (CHDH) in implementing these programs.

(3) Receive and interpret preventive medicine activity or installation water engineer reports on fluoride concentrations in terms of its relevance to prescribing and treatment practices on children and adults. The DRO will provide expertise concerning fluoride practices to health care providers, water engineers, and preventive medicine activities (see TB MED 576).

(4) Submit, through DENTAC/DCC commanders or dental unit commanders, a semiannual report on the Army Community Oral Health Protection Program (see para 9). This report will be electronically filed through the CDA.

(5) Encourage all dental personnel to take an active role in the Army Dental Readiness and Community Oral Health Protection Programs. The DRO will provide officer, enlisted, civilian personnel, and contract dental health care providers with current information on all aspects of preventive dentistry, disease prevention, and health promotion activities.

j. The CHDH, where assigned, will assist the DRO as requested. Responsibilities will include the planning, development, and administration of the Army Community Oral Health Protection Program.

k. Officer, enlisted, civilian, and contract dental staff of all DENTACs/DCCs dental units will conduct clinical operations consistent with good preventive practice and support community health promotion and wellness programs.

5. Scope of the program

The Dental Readiness and Community Oral Health Protection programs include the following components:

a. Dental Readiness Program (see para 6).

b. Clinical Oral Health and Health Promotion Program (see para 7).

c. Community Health Promotion and Disease Prevention Program (see para 8).

d. Community Oral Health Protection Report (see para 9).

6. Dental Readiness Program

Unit commanders, the dental care system, and the soldier share responsibility for dental readiness. The Dental Readiness Program provides the methods to reduce the risk of soldiers becoming non-combat dental casualties when such an event would jeopardize mission accomplishment.

a. Program methods. These include the following:

(1) An annual dental examination requirement in which a dental classification of the risk of having a non-combat dental emergency is assigned to each soldier.

(2) Monthly dental readiness reports to unit commanders about the dental risk profile of the unit.

(3) Priority appointment availability for those at high risk or without recent dental examinations (dental class 3 and class 4).

b. Dental classification. This is a dentist's best judgment of the risk of a patient having a dental emergency. Criteria are provided to assist the dentist in making the judgment (see HA Policy 02-011).

(1) *Class 1.* Patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are worldwide deployable.

(2) *Class 2.* Patients with a current dental examination, who require non-urgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Class 2 patients are worldwide deployable. Patients in dental class 2 may exhibit the following:

(a) Treatment or followup indicated for dental caries or minor defective restorations that can be maintained by the patient.

(b) Interim restorations or prostheses that can be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials for which protective coverage is indicated.

(c) Edentulous areas requiring a prostheses but not on an immediate basis.

(d) Periodontium that—

1. Requires oral prophylaxis.

2. Requires maintenance therapy.

3. Requires treatment for slight to moderate periodontitis and stable cases of more advanced periodontitis.

4. Requires removal of supragingival or mild to moderate subgingival calculus.

(e) Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal.

(f) Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployments up to 6 months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.

(g) Temporomandibular disorder patients in remission. The provider anticipates the patient can perform duties while deployed without ongoing care and any medications or appliances required for maintenance that will not interfere with duties.

(3) *Class 3.* Patients who require urgent or emergent dental treatment. Class 3 patients normally are not considered to be worldwide deployable.

(a) Treatment or followup indicated for dental caries, symptomatic tooth fracture, or defective restorations that cannot be maintained by the patient.

(b) Interim restorations or prosthesis that cannot be maintained for a 12-month period.

(c) Patients requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months:

1. Acute gingivitis or pericoronitis.

2. Active progressive moderate or advanced periodontitis.

3. Periodontal abscess.

4. Progressive mucogingival condition.

5. Periodontal manifestations of systemic disease or hormonal disturbances.

6. Heavy subgingival calculus.

(d) Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication, or acceptable esthetics.

(e) Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.

(f) Chronic oral infections or other pathologic lesions including:

1. Pulpal, periapical, or resorptive pathology requiring treatment.

2. Lesions requiring biopsy or awaiting biopsy reports.

(g) Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely followup care (for example, drain or suture removal) until resolved.

(h) Acute temporomandibular disorders requiring active treatment that may interfere with duties.

(4) *Class 4.* Patients who require periodic dental examinations or patients with unknown dental classifications. Class 4 patients normally are not considered to be worldwide deployable.

c. Procedures.

(1) Soldiers' records will be screened on arrival at a new permanent duty station.

(a) Active Army inprocessing permanent duty soldiers whose dental records indicate no examination within the previous 6 months or who are class 3 or class 4 must have a dental examination at the local dental clinic prior to completing their inprocessing procedures. Every effort will be made to achieve dental class 1 or class 2 for all inprocessing soldiers prior to the soldier reporting to his or her unit.

(b) Those soldiers whose records indicate they are in class 1 or class 2 will have their next annual dental examination no later than 13 months from the date of completion of their last dental readiness classification or their last dental examination (see HA Policy 96-023).

(c) Records will also be screened to ensure a panoramic radiograph is present in the record and that it is of adequate quality for diagnostic/identification purposes. If no panoramic radiograph is present, one will be taken and placed in the dental record. There is no time requirement on updating panoramic radiographs. However, the radiograph will adequately represent the current oral conditions of the soldier.

(2) Whenever available, depending on local dental assets and availability of time during the training cycle, soldiers in basic training or advanced individual training will be required to have a dental readiness examination. If no examination occurs at this time, soldiers must be examined at their first permanent duty station immediately upon inprocessing.

(3) Soldiers will have their dental readiness classification updated annually by a clinical examination. Soldiers who fail to receive a dental examination by the last day of the 13th month from the date of their last examination or dental readiness update will automatically become a dental class 4 and thus convert to a non-deployable status.

(4) Appointments for dental treatment required to achieve a satisfactory dental readiness status will be provided.

(a) Soldiers in dental class 1 require no treatment.

(b) Soldiers in dental class 2 will be counseled on their dental needs and every effort will be made to move that patient to dental class 1.

(c) Soldiers in dental class 3 will have the condition causing the potential dental emergency described in the narrative portion of an SF 603 (Health Record-Dental) so they may be reclassified to class 1 or class 2 as soon as the condition is corrected. Personnel in dental class 3 will receive expedited treatment to remove them from this unsatisfactory dental classification. The immediate goal of expedited treatment is to take care of the patient's most urgent dental needs and eliminate a probable dental emergency.

(5) Prior to a soldier's reassignment to an overseas location, dental records will be screened and active duty personnel found to be in dental class 3 or class 4 will not be cleared for overseas movement until dental treatment places them in at least dental class 2 or unless otherwise approved in accordance with DA Pam 600-81, paragraph 2-111(5)l. This dental screening should be completed at least 7 days prior to the soldier's actual rotation date.

(6) Dental classifications 3 and 4 normally will not deploy unless, under extreme circumstances, a waiver is granted by the installation commander, with recommendation from the dental activity in the grade of O6 or above (see DA Pam 600-81, para 2-111(5)).

d. Reserve Dental Readiness and DD Form 2813 (DOD Active Duty/Reserve Forces Dental Examination). Commanders of Reserve Component soldiers are responsible for the dental readiness of their units. DD Form 2813 applies to members of the Reserve Components and documents their dental health following annual dental examinations performed by civilian dentists. The following information details proper utilization of DD Form 2813:

(1) *Use of the form.* Military members receiving a dental examination from a civilian dentist will request their dentist's assistance in completing DD Form 2813. The Government is not obligated to pay for administrative costs (if any) incurred for completing the form. Military dentists (Active Army and Reserve Component) will continue to document annual dental examinations on SF 603 and SF 603A (Health Record-Dental-Continuation).

(2) *Completion of DD Form 2813.* The individual being screened will fill out blocks 1 through 5, and request his or her civilian dentist to complete the remainder of the form (blocks 6 through 11). These blocks are self-explanatory.

(3) *Use by active duty soldiers.* Active duty soldiers who are stationed in isolated areas where military care or facilities may not be available may also use this form. These soldiers may use this form to document their readiness status by having their annual exam done by a civilian dentist and then forwarding DD Form 2813 to their unit.

(4) *Disposition.*

(a) The Reserve Component member is responsible for forwarding the completed form to the unit's personnel section for filing in the member's dental health record.

(b) The results of each exam (the member's dental fitness classification) will be entered into the authorized electronic tracking system (either CDA or MEDPROS) so that dental fitness status reports can be made available to the unit commander and to higher headquarters. Dental fitness classifications are as follows:

1. *Dental fitness class 1.* Soldiers with a form that has an "X" in block 6, item (1), will be classified in dental fitness class 1.

2. *Dental fitness class 2.* Soldiers with a form that has an "X" in block 6, item (2), will be classified in dental fitness class 2.

3. *Dental fitness class 3.* Soldiers with a form that has an "X" in block 6, item (3), will be classified in dental fitness class 3.

(c) DD Form 2813 will be filed on the right side of the dental record treatment folder below the SF 603 and SF 603A (see AR 40-66, fig 5-3).

e. Organizational responsibilities.

(1) *Units.* The unit commander is responsible for the dental readiness of the assigned soldiers. The unit commander will establish procedures to carry out the requirements of the Dental Readiness Program. Commanders will make their personnel available for appointments and maintain surveillance over the program to ensure the following:

(a) The supporting unit's dental clinic will be the sole custodian of all unit personnel dental records. Newly arriving soldiers will turn in their dental records to dental personnel for initial screening.

(b) When outprocessing a duty station, soldiers whose records indicate no examination in the previous 6 months or who are a dental class 3 or class 4 will have dental examinations prior to completing their outprocessing procedures. If soldiers should outprocess without achieving dental class 1 or 2, they will be given priority care at their next duty location for a dental examination and/or to eliminate the emergent dental care problem. The unit's executive officer and senior noncommissioned officer will be notified to assure followup care through the supporting dental clinic.

(c) All soldiers in the unit will receive annual dental examinations. The unit (or its supporting personnel activity) will—

1. Provide current rosters of soldiers in the unit to the dental facility that supports the soldier. The supporting dental clinic will provide rosters (through both MEDPROS and CDA) to the unit both at 60 and 30 days prior to the soldier's conversion date to dental class 4. The supporting dental clinic will also notify soldiers of the suspense for their annual dental examination and renotify them in case of noncompliance.

2. Make soldiers identified as class 3 or class 4, or soldiers who require an annual dental examination, available for compliance with the program.

3. Establish procedures to deal with soldiers who are in repeated noncompliance.

(d) Emphasis will be placed on ensuring that soldiers, who are being newly assigned to recruiting duty, full-time manning programs for the Reserve Components, Reserve Officers' Training Corps duty, and Military Assistance Group or Embassy duty, are in class 1 before departing for their new assignments.

(e) Emphasis will be placed on ensuring that soldiers in early deployment forces are maintained in a class 1 or class 2 status.

(2) *DENTAC/DCC/dental units.* DENTAC/DCC/dental unit commanders are responsible for assisting supported units in maintaining the readiness of soldiers. DENTAC/DCC/dental unit commanders are responsible for the following functions:

(a) Serve as dental readiness advisors to unit commanders to assure compliance with the goal of 95 percent dental readiness (dental class 1 and class 2 combined).

(b) Screen dental records of newly arrived soldiers to establish their dental readiness classification.

(c) Assist unit commanders in the elimination of class 3 and class 4 ratings by timely unit notification and coordination of appointments. Rosters will be delivered in person or made available electronically both at 60 and 30 days prior to the soldier's required annual examination date.

(d) Provide monthly updates to the unit or its supporting personnel activity on changes in soldiers' dental classification and date of last dental examination.

(e) Annually, conduct an audit of dental records against the unit's Dental Readiness Program roster located in CDA.

7. Clinical Oral Health and Health Promotion Program

This program consists of measures provided in Army dental clinics to prevent injury, oral disease, and promote health. DROs and CHDHs will encourage use of these measures to the greatest extent possible by all dental health care providers.

a. Exam and treatment planning.

(1) Initial, periodic, and comprehensive oral evaluations will include caries, tobacco, periodontal, and oral cancer risk assessments.

(2) Sealants should be considered in both children and adults as a preventive measure.

(3) Blood pressure readings that indicate hypertension should be referred to appropriate medical facilities and followed-up at subsequent appointments.

(4) When indicated, the patient should be informed of risk of skin and lip cancer from sun exposure.

(5) Mouthguards should be included in the treatment plan when soldiers are at risk for maxillofacial injuries from sport, recreation, or occupation.

(6) At the annual examination and all other dental encounters, dental providers should be alert to the signs of family abuse and neglect as provided by the P.A.N.D.A protocols. When there are signs consistent with abuse and neglect, providers are required to report these findings in accordance with AR 608-18.

b. Dental prophylaxis. Active duty soldiers and other eligible beneficiaries should be provided with a thorough dental prophylaxis as needed. Frequency of dental prophylaxis should be based upon risk assessment. Unless contraindicated, an American Dental Association (ADA) approved topical fluoride agent should be applied for patients at risk for dental disease.

c. Fluoride. The method, dose, and frequency of fluoride therapy should be based upon risk assessment.

(1) Professionally apply topical fluoride as needed.

(2) Base use of fluoride supplements for children on age, exposure history, and risk. Dental readiness officers and CHDHs should assist health care providers in understanding ADA supported criteria and local exposure factors.

(3) Prescribe home rinse as needed.

d. Counseling.

(1) Individual oral hygiene instruction. Identify plaque as a cause of caries and periodontal disease. Advise patients on plaque control. When appropriate, information on maintaining oral health in a field environment should be included.

(2) Nutrition counseling. Provide nutrition counseling to individuals when indicated by risk assessment. There should be an emphasis on the relationship caries and periodontal risk to the type of food, carbohydrate content, and frequency and timing of intake.

(3) Tobacco counseling. Use the recommendations outlined in the Public Health Service publication on "Treating Tobacco Use and Dependence" (see app A). Individuals who use tobacco and are willing to quit should be treated using the "5 A's": ASK all patients about the type and frequency of use; ADVISE on the adverse effects, especially as

it relates to oral cancer and periodontal health; ASSESS their willingness for cessation; ASSIST in setting a quit date; and ARRANGE for organized tobacco intervention services by referral as necessary.

8. Community Health Promotion and Disease Prevention Program

a. Fluoridation of community water supply. Controlled fluoridation of the community water supply is the principal community dental public health measure to prevent caries.

(1) Fluoridation of post water supplies should take place when—

(a) The level of natural fluoridation is less than one-half the optimal concentration for that climate.

(b) The fluoridation process is otherwise considered practical and feasible (see TB MED 576).

(2) It is the responsibility of the DRO/CHDH to advise the preventive medicine officer and installation engineer concerning the optimal concentrations of fluoride. Where natural fluoridation exceeds acceptable levels, defluoridation measures should be recommended.

b. Alternative fluoride administration. Programs for alternative fluoride administration, such as fluoride supplements, should be available for family members who are not drinking fluoridated water. The DRO will advise physicians and dentists on professional guidelines for prescribing fluorides in concurrence with the ADA.

c. Family violence. A system for reporting suspected cases of family violence that involve abuse or neglect will be coordinated with the local Family Advocacy Program per AR 608–18. An example of abuse would be head or facial injuries inconsistent with the stated cause. If parents have been informed of dental abscesses, large carious lesions, or extensive periodontal disease but have not taken corrective action, referral for child neglect may be indicated.

d. Community education. The DRO and CHDH will partner with the medical and installation communities to promote oral health/health promotion to the broadest audience possible.

e. School-based programs.

(1) Each DENTAC/DCC, or dental unit will establish a cooperative relationship with any Department of Defense Dependent School in its area of responsibility. The DENTAC/DCC will encourage oral health education and support teacher training, classroom activities, and school health officials in the dental health education efforts.

(2) DENTAC/DCC activities recommended include but are not limited to—

(a) Oral screening, with parental consent; results should be reported to parents and school health officials.

(b) Comprehensive age appropriate oral health instruction. It should include brushing, flossing, diet counseling, and the appropriate use of fluorides. Sports safety (mouthguards), tobacco interdiction, sealants, and sun safety are also recommended as part of the health promotion message when suitable.

(3) The operation of the Community Health Promotion and Disease Prevention Program will not interfere with necessary dental services for active duty soldiers or with the provision of emergency care.

9. Community Oral Health Protection Report

a. A Community Oral Health Protection Report (RCS MED 399) will be submitted semiannually, in a format prescribed by the DENCOM. Data for the reporting period of 1 October to 31 March will be submitted electronically through CDA from the DENTAC/DCC to DENCOM by 30 April. The 1 April to 30 September report will be due by 31 October. CDA will automatically submit the completed reports to the Regional Dental and DENTAC Commanders for their review.

b. A copy of the report will be furnished to the installation commander within 30 days of completing the report.

c. DENCOM will consolidate subordinate units' Community Oral Health Protection Reports and forward the final report to TSG's consultant in Dental Public Health for review. These consolidated reports are due by 31 May and 30 November.

Appendix A References

Section I Required Publications

AR 40-66

Medical Record Administration and Health Care Documentation. (Cited in para 6d(3)(c).)

AR 608-18

The Army Family Advocacy Program. (Cited in paras 4f(6), 7a(6), and 8c.)

DA Pam 600-81

Information Handbook for Operating Continental United States (CONUS) Replacement Centers and Individual Deployment Sites. (Cited in paras 6c(5) and 6c(6).)

TB MED 576

Occupational and Environmental Health: Sanitary Control and Surveillance of Water Supplies at Fixed Installations. (Cited in paras 4g(2), 4i(3), and 8a(1)(b).)

Section II Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

AR 11-2

Management Control

AR 40-3

Medical, Dental, and Veterinary Care

AR 600-8-101

Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing)

HA Policy 96-023

Dental Readiness Within the Services (<http://www.ha.osd.mil/policies>)

HA Policy 96-024

Inclusion of Dentistry in TRICARE Regions (<http://www.ha.osd.mil/policies>)

HA Policy 02-011

Policy on Standardization of Oral Health and Readiness Classifications (<http://www.ha.osd.mil/policies>)

HA Policy 98-021

Policies on Uniformity of Dental Classification, System, Frequency of Periodic Dental Examinations, Active Duty Overseas Screening, and Dental Deployment Standards (<http://www.ha.osd.mil/policies>)

RCS MED 399

Community Oral Health Protection Report. (Available from the U.S. Army Dental Command (MCDS), 2050 Worth Rd., Ste. 4, Fort Sam Houston TX 78234-6000; commercial: 210-221-8241; DSN: 471-8241.)

Treating Tobacco Use and Dependence: Clinical Practice Guidelines

Fiore MC, Bailey WC, Cohen SJ, et al. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, June 2000 (<http://www.surgeongeneral.gov/tobacco/>)

Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians

Fiore MC, Bailey WC, Cohen SJ, et al. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, October 2000 (<http://www.surgeongeneral.gov/tobacco/>)

Section III Prescribed Forms

DD Form 2813

DOD Active Duty/Reserve Forces Dental Examination. (Prescribed in para 6d.) (<http://web1.whs.osd.mil/icdhome/icdhome.htm>)

Section IV Referenced Forms

DA Form 11-2-R

Management Control Evaluation Certification Statement

SF 603

Health Record-Dental

SF 603A

Health Record-Dental-Continuation

Appendix B Management Control Evaluation

B-1. Function

The functions covered by this evaluation are dental readiness and community oral health protection.

B-2. Purpose

The purpose of this evaluation is to assist dental personnel in Army dental facilities in evaluating the key management controls listed below. It is not intended to cover all controls.

B-3. Instructions

Base answers on the actual testing of key management controls (for example, document analysis, direct observation, sampling, other). Explain answers that indicate deficiencies and indicate corrective action in supporting documentation. Document certification on DA Form 11-2-R (Management Control Evaluation Certification Statement). This form is available on the Army Publishing Directorate Web site.

B-4. Test questions

- a. Are units reviewing all dental records annually?
- b. Are soldiers' records being screened when they arrive at a new duty station?
- c. Do the dental records contain a dental classification noted on SF 603?
- d. Do dental records contain a good quality panoramic radiograph?
- e. Do dental records of Reserve Component soldiers contain a DD Form 2813 when they don't have a current military dental examination?
- f. Are units providing current rosters of soldiers to their supporting dental facility?
- g. Are the supporting dental activities providing rosters to the unit at both 60 and 30 days before a soldier's conversion date to dental class 4?
- h. Are supporting dental activities notifying soldiers of the suspense for their annual dental examination and renotifying them in case of noncompliance?
- i. Are soldiers receiving an annual dental examination?
- j. Are personnel in dental class 3 and class 4 being provided expedited treatment?
- k. Are unit commanders monitoring dental appointments within their units?
- l. Has the unit met the goal of having 95 percent of its soldiers in dental class 1 or class 2?
- m. Are the components of the Community Oral Health Protection Report submitted on time at all levels?
- n. Have dental providers been educated in how to recognize and report signs of family abuse and neglect?

B-5. Supersession

This evaluation replaces the checklist published in DA Circular 11-87-1.

B-6. Comments

Help make this a better tool for evaluating management controls. Submit comments to HQ U.S. Army Dental Command (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

Glossary

Section I Abbreviations

ADA

American Dental Association

CDA

Corporate Dental Application

CHDH

community health dental hygienist

DCC

dental clinic command

DENCOM

U.S. Army Dental Command

DENTAC

dental activity

DRO

dental readiness officer

MEDPROS

Medical Protection System

TSG

The Surgeon General

Section II Terms

P.A.N.D.A.

An educational coalition, organized at the State level, that provides programs aimed at increasing awareness of child abuse and neglect and helping dental personnel recognize and report suspected cases.

Section III

Special Abbreviations and Terms

This section contains no entries.

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